513-111 AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CONSULTATION SHEET**

REQUEST

TO: Optometry / Dr Gabriel | FROM: (Requesting physician or activity) | DATE OF REQUEST: 09/20/04

REASON FOR REQUEST (Complaints and findings)

Inmate S/P (L) orbital Fx, has rx eyeglasses (L) eye

Please evaluate IOP/refraction still OK (Recently arrived from another institution) Thanx!

PROVISIONAL DIAGNOSIS: L injury occurred 2/04

As Above

DOCTOR'S SIGNATURE: ROSS QUINN, M.D. MEDICAL OFFICER | APPROVED: mm | PLACE OF CONSULTATION: ☐ BEDSIDE ☐ ON CALL | ☐ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☑ YES ☐ NO | PATIENT EXAMINED ☑ YES ☐ NO | TELEMEDICINE ☐ YES ☑ NO

Dilated on up page. Present Rx ok

V 20/20
PH 20/20

Visions show L eye restricted in up gaze.

11/18/04 - all as before, no apparent change DG

ROSS QUINN, M.D. MEDICAL OFFICER
OCT 25 2004

(Continue on reverse side)

SIGNATURE AND TITLE: D Gabriel OD DAVID E. GABRIEL, O.D. | DATE: 10/21/04

HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT | DEPARTMENT/SERVICE OF PATIENT

RELATION TO SPONSOR | SPONSOR'S NAME (Last, first, middle) | SPONSOR'S ID NUMBER (SSN or Other) FSL ELKTON

PATIENT'S IDENTIFICATION (For typed or written entries give: Name–last, first, middle; ID no. (SSN or other); Sex; Date of Birth; Rank/Grade) | REGISTER NO. | WARD NO.

Baker, Darryl
19613-039
06/30/62

CONSULTATION SHEET
Medical Record
STANDARD FORM 513 (REV. 4-98) 000135
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11 .203(b)(10)

513-111

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — CONSULTATION SHEET

REQUEST

TO: VR Comm. Ophthalmology

FROM: (Requesting physician or activity) ROSS QUINN M.D.

DATE OF REQUEST: SEP 20 2004

REASON FOR REQUEST (Complaints and findings)

Inmate w/ th assault Feb 04 → L orbital fx & entrapment SX L eye. Has ophthalmology consult from another institution dated June 11, 2004 recommending surgery to release L eye (attached)

PROVISIONAL DIAGNOSIS Has pain, diplopia & superior gaze especially. Vision Eglasses 20/20 OU. Last date = Dec 2012.

DOCTOR'S SIGNATURE: ROSS QUINN M.D. MEDICAL OFFICER

APPROVED

PLACE OF CONSULTATION: ☐ BEDSIDE ☒ ON CALL

☒ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

RECORD REVIEWED ☒ YES ☐ NO

CONSULTATION REPORT

PATIENT EXAMINED ☒ YES ☐ NO

TELEMEDICINE ☐ YES ☐ NO

Patient evaluated by Optometrist and Mohammed Azam Administrator

(Continue on reverse side)

SIGNATURE AND TITLE

DATE

HOSPITAL OR MEDICAL FACILITY

RECORDS MAINTAINED AT

DEPARTMENT/SERVICE OF PATIENT

RELATION TO SPONSOR

SPONSOR'S NAME (Last, first, middle)

SPONSOR'S ID NUMBER (SSN or Other)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name–last, first, middle; ID no. (SSN or other); Sex; Date of Birth; Rank/Grade)

REGISTER NO.

WARD NO.

Baker, Darryl
19613-039
06/30/62

HEALTH SERVICES
CONSULTATION SHEET
FSL, ELKTON, OH
Medical Record

STANDARD FORM 513 (REV. 4-98)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11 .203(b)(10)

000136

SENECA EYE SURGEONS

Robert J. Weiss, M.D. Timothy J. O'Brien, M.D. Nicholas A. Stathopoulos, M.D.

June 11, 2004

19613-039

Dennis Olson, M.D.
FCI McKean
P.O. Box 5000
Bradford, PA 16701

RE: BAKER, DARRYL

Dear Dr. Olson:

As you know we have been following Mr. Baker's clinical diplopia related to a punch that gave him a blow out fracture. He also has a little bit of anesthesia involving the infraorbital nerve branches. We have given it plenty of time now, almost five months. He still has entrapment; he can not look up with his left eye without experiencing a form of diplopia that gives him extreme imbalance. He does not think that he can function this way.

His acuity is 20/20 in both eyes when he wears his glasses. My advice at this point is to do a repair of blowout fracture, release the entrapment under general anesthesia. I will leave the final decision up to you.

Yours truly,

Robert J Weiss MD

Robert J. Weiss, M.D.

p.s. The patient understand that one of the side effects of doing the operation when he does not have diplopia in down gaze, only up gaze would be that he might develop diplopia in down gaze. There is no way that I can promise him that that couldn't happen.

RJW/lab

H. BEAM, MD
FCI MCKEAN
07/16/04

103 West St. Clair Street
Warren, PA 16365
(814)726-2020
1-877-MD4-EYES
Fax (814)726-1215

27 Porter Avenue
Jamestown, NY 14701
(716)483-2020
1-866-716-EYES
Fax (716)488-9295

2 Main Street
Bradford, PA 16701
(814)362-7477
1-866-814-EYES
Fax (814)362-4975

513-111 AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CONSULTATION SHEET**

REQUEST

TO:	FROM: (Requesting physician or activity)	DATE OF REQUEST
Optometry / Dr Gabriel		09/20/04

REASON FOR REQUEST (Complaints and findings)

Inmate s/p (L) orbital fx, has sx entrapment (L) eye
Please advise IOP/refraction still OK (Recently arrived from another institution) Thanx!

PROVISIONAL DIAGNOSIS

As Above

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	
[signature]	O	☐ BEDSIDE ☐ ON CALL	☐ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO PATIENT EXAMINED ☐ YES ☐ NO TELEMEDICINE ☐ YES ☐ NO

(Chart Copy)

(Continue on reverse side)

SIGNATURE AND TITLE	DATE

HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	DEPARTMENT/SERVICE OF PATIENT

RELATION TO SPONSOR	SPONSOR'S NAME (Last, first, middle)	SPONSOR'S ID NUMBER (SSN or Other)
		FSL ELKTON

PATIENT'S IDENTIFICATION (For typed or written entries give: Name--last, first, middle: ID no. (SSN or other); Sex; Date of Birth: Rank/Grade)	REGISTER NO.	WARD NO.
Baker, Darcy / 19613-039 06/30/62		

CONSULTATION SHEET
Medical Record

STANDARD FORM 513 (REV. 4-98)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11 .203(b)(10)

000138

SENECA EYE SURGEONS

Robert J. Weiss, M.D. Timothy J. O'Brien, M.D. Nicholas A. Stathopoulos, M.D.

April 16, 2004

#19613-039

Dr. H. Beam
Health Center
FCI McKean
PO Box 5000
Bradford, PA 16701

Re: Darryl O. Baker
DOB: 6/30/1962
DX: Orbital Floor Fracture w/Entrapment
DATE OF EVAL: 4/15/04

Mr. Baker was seen April 15th. He had been struck in the left eye February 27th with a fist. He was complaining of blurred vision in both eyes. He does note that he gets double vision when he looks up. This is especially noticeable when he is weight lifting and doing, I believe, bent over rows and is looking straight ahead with his head tilted down.

His vision was 20/100 in the right eye and 20/200 on the left. This was easily correctable to 20/20 in either eye with an eyeglass prescription. The eyes were well aligned straight ahead. However, with up gaze the left eye did not elevate or look as far up as the right eye. I did not see any signs that the left eye was protruding further out or recessed into the eye more so than the right. The retina was normal.

The reports of the CT did suggest that there was some scarring of the floor of the orbit with possible adhesions to the inferior rectus muscle. Typically, in ophthalmology even with a fracture of the orbital floor, we like to wait at least two weeks to see that it heals on its own and the muscle entrapment is resolved. He is about six to eight weeks out and complaining of symptoms. Because he is well aligned at near, I think it would be better to take a conservative approach as the scarring is adherent to the muscle. However, it may be worthwhile to get a secondary opinion from an orbital plastic specialist who deals with these on a regular basis.

Thank you for allowing me to participate in Darryl's care. If you do not pursue an orbital evaluation, have him see me again in another three months.

Best regards,

N Stathopoulos, MD

Nicholas A. Stathopoulos, M.D.

NAS/js

Cc Darryl C. Baker

REVIEWED BY: H. BEAM, MD FCI MCKEAN 4/21/04

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www.senecaeye.com

SENECA EYE SURGEONS

Robert J. Weiss, M.D. Timothy J. O'Brien, M.D. Nicholas A. Stathopoulos, M.D.

April 16, 2004

19613-039

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N Stathopoulos, MD

Nicholas A. Stathopoulos, M.D.

NAS/js

Cc Darryl C. Baker

REVIEWED BY: 4/21/04
H. BEAM, MD
FCI MCKEAN

000140

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1613-039

SENECA EYE SURGEONS, INC.

103 W. ST. CLAIR ST., WARREN, PA 16365 814-726-2020
27 PORTER AVE., JAMESTOWN, NY 14701 716-483-2020
2 MAIN ST., BRADFORD, PA 16701 814-362-7477

PATIENT'S NAME Darryl Baker DATE 4/15/04

ADDRESS

MEDICARE NO. SURGERY DATE

Rx	SPH	CYL	AXIS	PRISM	BASE
OD	-1.75	+1.00	090		
OS	-2.00	+1.25	090		
ADD	+1.25	SPECIAL INSTRUCTIONS			
ADD	+1.25	POLYCARBONATE LENSES RECOMMENDED			

DIAGNOSIS V43.1 / 379.31 OD / OS PROGNOSIS

PRESCRIPTION DURATION 6 MOS

Nicholas Stathopoulos, MD
PHYSICIAN'S SIGNATURE

PAUL O. KEVERLINE, M.D.
PA LIC. MD-011817-E
NY LIC. 170334-1

ROBERT J. WEISS, M.D.
PA LIC. MD-022030-E
NY LIC. 127219-1

TIMOTHY J. O'BRIEN, M.D.
PA LIC. MD-047466-L
NY LIC. 195904-1

NICHOLAS A. STATHOPOULOS, M.D.
PA LIC. MD-071144-L
NY LIC. 205998-1

CHARLES E. KELLER, O.D.
PA LIC. OE-005123-P

SES017

SENECA EYE SURGEONS

Robert J. Weiss, M.D. Timothy J. O'Brien, M.D. Nicholas A. Stathopoulos, M.D.

June 11, 2004

19613-039

Dennis Olson, M.D.
FCI McKean
P.O. Box 5000
Bradford, PA 16701

RE: BAKER, DARRYL

Dear Dr. Olson:

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13-110 NSN 7540-00-634-4127

MEDICAL RECORD — CONSULTATION SHEET

REQUEST

TO:	FROM: (Requesting physician or activity)	DATE OF REQUEST
OPTOMETRIST	Dennis Olson, MD, CD	

REASON FOR REQUEST (Complaints and findings)

EYE EXAM:

SUBJECTIVE: Inmate after and seen consulted Feb 27th age 41

PROVISIONAL DIAGNOSIS: Intin left eye socket

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION			
D. OLSON, M.D.	O	☐ BEDSIDE	☐ ON CALL	☐ ROUTINE	☐ TODAY
				☐ 72 HOURS	☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO PATIENT EXAMINED ☑ YES ☐ NO

Visual Acuity Distance OD 20/200 OS 20/200 TONOMETRY: OD 17 OS 18

Near OD .37m OS .37m uncorrected 0950

External normal 72/64

Internal open angles delete to examine retina

Refraction OD -1.00 -1.25x180 20/20

OS -1.00 -1.25x10 20/20

53K x 24 x 6½ Soreness

Diagnosis CMA

Analysis requires eyeglasses on upward gaze left eye stops trauma to eye socket possible left superior oblique entrapment

Plan order eyeglasses

(Continue on reverse side)

SIGNATURE AND TITLE		DATE
Christian J. Hovanec		3/3/04

IDENTIFICATION NO.	ORGANIZATION	REGISTER NO.	WARD NO.
	FCI McKean	1613-039	

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

Baker, David

REVIEWED BY H. BEAM, MD FCI McKEAN 3/3/04

Order for MRI of eye orbit ordered

CONSULTATION SHEET Medical Record

STANDARD FORM 513 (REV. 8-92) Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9

000143 Refer to optometry

BILL TO:

Baker

PT A 11

PATIENT NAME	CUST. NUMBER	INVOICE NUMBER
19613-039 LI-1 110666		

Tray No. 9815 Date Processed

	Sphere	Cylinder	Axis	Prism	Base Curve
R. EYE	-1.00	-1.25	180		
L. EYE	-1.00	-1.25	10		

	Add	Width	Height		P.D.	N.P.D.
R. EYE			0.0	R. EYE		
L. EYE			0.0	L. EYE		

FRAME DATA

Size	Depth	E.D.	D.B.L.
52.0	46.0	56.0	24.0

Model: 032027e137 TMPL. Length: 52X24

83-84 SMOKE

EDGED UNCUT [X] LENS ONLY [ ] ENCLOSED [ ] TO COME [ ] SUPPLIED [ ]

LENS DATA

	Type	Material
R:	SV CR-39 SRC1 SOLA T2	
L:	SV CR-39 SRC1 SOLA T2	

FDA CODE SEC. 3, 84, 21 CFR

THESE LENSES ARE IMPACT RESISTANT AND IN COMPLIANCE WITH FDA TESTING PRESCRIBED IN SEC. 3, 84, 21 CFR IMPACT RESISTANT LENSES ARE NOT UNBREAKABLE OR SHATTERPROOF.

NOTE FOLLOWING EXCEPTIONS

(1) PLASTIC: Mfr. certifies lenses ground to specifications are impact resistant within FDA code.
(2) UNCUT GLASS lenses have not been treated or tested and must be made impact resistant before dispensing.
(3) RAISED LEDGE multifocals have been made impact resistant, but are exempted from drop ball testing.

COMMENTS:

J-10219303 LI-1 T-9875

OPT A 20

RP

CHARGES

DESCRIPTION	PRICE
[redacted]	
Sub Total	
Freight	
Total Due	

/s/ Darryl Baker

FROM: 110666 8/18 POSTMASTER
IF THIS PACKAGE IS NOT DELIVERED IN FIVE DAYS, PLEASE RETURN TO SENDER

SHIP TO:
FCI MCKEAN HE/
RT 59 BIG SHAN
LEWIS RUN PA 16

Eyeglass Prescription

TRAY NO. | ARRIVAL DATE | PRESCRIPTION NO.

INSTITUTION:

CITY

STATE ZIP

LENSES

EXTRA

FRAME OR MTG

MISC

BAKER, Darrel
19613-039
FCI - Yankton

		SPHERE	CYLINDER	AXIS	PRISM	DIRECTION	IN DEC OUT
DISTANCE	R	-1.00	-1.25	180			
	L	-1.00	-1.25	10			
ADD	R						
	L						

SEGMENT INSTRUCTIONS: HEIGHT R / L; WIDTH; INSET R / L; PUPILLARY WIDTH DIST. 32; NEAR X

SEG. STYLE	ORTH. F TILLER D	EXECUTIVE TYPE	KRYPTOK	PANOPTIK	CURVED TOP	TRIFOCAL AND TYPE	STRAIGHT TOP	OTHER.
	22		22	22 - 24	22 - 25		22 25 28 35 45	

FRAME OR SHAPE		EYE SIZE	BRIDGE SIZE	TEMPLE LENGTH AND STYLE
29	Smoke	52	24	6 1/4

SPECIAL INSTRUCTIONS
( ) LENS ONLY
( ) FRAMES ONLY
Plastic

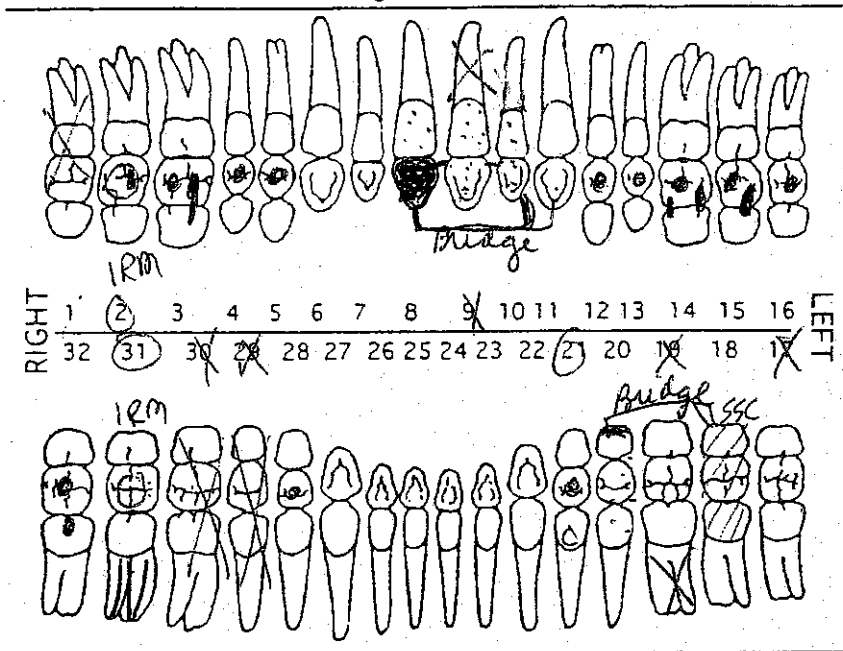
Mail to:
Federal Prison Industries
Box 100
Butner, N.C. 27509

Christine J. Howard 3/31/04
SIGNATURE DATE
USP LVN

BP-357(60)
MAY 1984

BP-S618.060 **CLINICAL DENTAL RECORD** CDFRM
AUG 96
U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

Examination: ☐ Screening ☐ Comprehensive ☐ Periodic



Occlusion Cl I

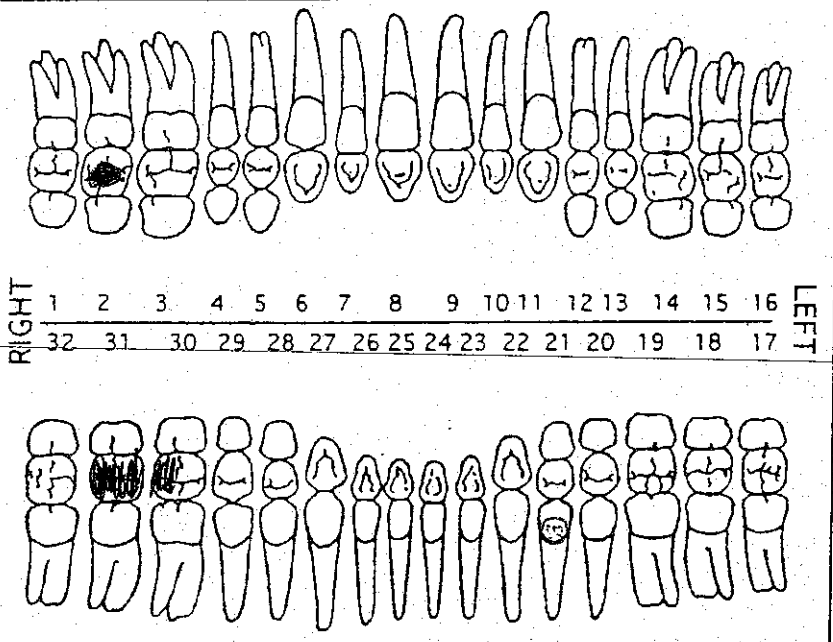
Oral Hygiene
Good (Fair) Poor

CPITN 2 | 2 | 3
2 | 2 | 2

Head & Neck/Soft Tissue
WNL

Additional Findings
D: 3
M: 5
F: 14

Treatment Completed



Recommended Treatment Plan

~~3~~ Radiographs
~~2BW Pan X~~

☐ ~~Dental Prophylaxis~~ 1-6-05
☐ ~~Oral Hygiene Instruction~~

☐ ~~Periodontal Evaluation~~ 0 (I) II III

☐ Oral Surgical Procedures
0

☐ Endodontic
0

☐ Restorative
~~#20~~ ~~#31 CPA~~ PIC
~~#21B~~ ~~HH~~

☐ Prosthodontic Evaluation
0

Patient Name Number Sex: (M) F Age:

Baker, Darryl 19613-039

Dentist Signature Date

Charles Houck, DDS 11-16-04

000146

FSL ELKTON

Federal Bureau of Prisons Clinical Dental Records

Date/Time	#	Diagnosis - Treatment - Remarks
8-17-04		S: Sore tooth - points to #31
0800		O: Endo complete - defect temp - lost space to max.
		A: Dy. temp. #31 - possible endo failure
		P: No LA - re-temp #31 mo - caution pt to seek follow-up if persist. TA develops
		Charles Houck, DDS
11-16-04		Comp. exam. Head & neck exam, soft tissue
1300		CPITN, DMF, 2BW, Pan X; Medical history reviewed & updated. NV → hygiene
		Charles Houck, DDS
1-6-05		Med Hx needs done at next appt. - Perio
1000		Mod Sub/supragingival calc & Mod to heavy bleeding Hand scaled throughout polished & flossed OH given verbal & printed. NV: Ops/ Salisbury JACKIE SALISBURY RDH
2-2-05		LA 36mg lido, 0.018 epi
1200		Excavate 21O - A3.5 composite
		NV → 2° Charles Houck, DDS
2-18-05		LA 36mg lido, 0.018 epi
1200		Excavate dy SA #2° - optibond / SA
		Charles Houck, DDS
3-16-05		Build-up #31 as much as occlusal constraint
1000		allows - optibond / SA #31 MOD
		PTC
		Charles Houck, DDS

FEDERAL BUREAU OF PRISONS
DENTAL/MEDICAL HEALTH HISTORY FORM

1. Are you currently taking any medication? yes (no)
   If so, what? _____

2. Are you allergic to or have you had a reaction to any food, materials, medications or drug? yes (no)
   If so, what? _____

3. Have you been under the care of a physician during the past two years? If so, why? _____ (yes) no

4. Have you been hospitalized in the past two years? yes (no)
   If so, why? _____

5. Do you have or have you ever had a heart murmur or been treated for a heart condition? yes (no)

6. Do your ankles ever swell during the day? yes (no)

7. Have you ever been treated for a tumor or growth? yes (no)

8. Have you ever had abnormal bleeding? yes (no)

9. Have you ever had serious difficulty with any dental treatment? yes (no)

10. Have you ever had clicking, popping, or pain in your jaw-joint? (yes) no

Circle any of the following that you have had:

Congenital heart defects	Heart murmur
Heart attack or heart problems	Angina
Stroke	High Blood pressure
Rheumatic Fever	Heart pacemaker
Asthma	Epilepsy or seizures
Anemia (blood problems)	Diabetes
Thyroid problems	AIDS or HIV infection
Chronic bronchitis	Emphysema
Venereal disease (syphilis, gonorrhea)	Tuberculosis (TB)
Arthritis	Psychiatric treatment
Artificial heart valve	Artificial joint
Hepatitis	

Do you currently use tobacco (cigarettes, chewing tobacco, snuff)?
yes (no)

Do you have any disease, condition, or problem not listed?
WOMEN ONLY: Are you pregnant?

Name: Darryl BAKER Reg No. 19613-039

Signature: Darryl Baker

Institution: FSL Elkton Date: 02-02-05

FEDERAL BUREAU OF PRISONS

HISTORIA CLINICA DE ODONTOLOGIA Y MEDICA

1. Que medicinas esta tomando actualmente? Si No
   Si es si, el nombre _____

2. A que comida, materiales, medicinas es usted alergico? Si No
   Si es si, el nombre _____

3. Tuvo alguna enfermedad durante los ultimos dos anos que requirio ver un doctor? Si No
   Si es si, por que? _____

4. Ha estado usted en el hospital durante los ultimos dos anos? Si es si, por que? Si No
   _____

5. Tiene usted o ha tenido historial de un soplo en el corazon o ha sido tratado por alguna otra condicion cardiaca? Si No

6. Se le hinchan los pies? Si No

7. Tiene cancer? Desde cuando? _____ Si No

8. Sangra usted con exceso? Si No

9. Ha tenido problemas con algun tratamiento dental? Si No

10. Ha tenido usted alguna vez tembiores, dislocaciones o dolores en su mandibula? Si No

Que enfermedades o sintomas tiene? De reconocerlos una marca:

Defectos del corazon	Soplo cardiaco
Ataque del corazon	Angina
Apoplejia o derrame cerebral	Presion alta
Fiebre reumatica	Marcapasos
Asma o fatiga	Convulsiones
Anemia (problemas de sangre)	Diabetes
Proplemas de tiroies	SIDA o infeccion de HIV
Bronquitis	Enfisema
Enfermedad venerea (gonorrea/sifilis)	Tuberculosis
Artritis	Desordenes psiquiatricos
Valvulas artificiales	Coyunturas artificiales
Hepatitis (problemas del higado)	

Usa usted frecuentemente tabaco (cigarrillos, mascar, rape)? Si No

Tiene otras enfermedades que no esten en esta lista? Si No

LAS MUJERES: Esta usted embarazada o encinta? Si No

Firma: _____ Fecha: _____

Nombre _____ Numero _____

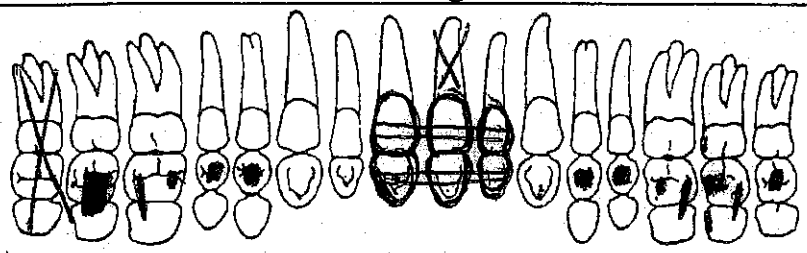
FSL Elkton

BP-S618.060 **CLINICAL DENTAL RECORD** CDFRM
AUG 96

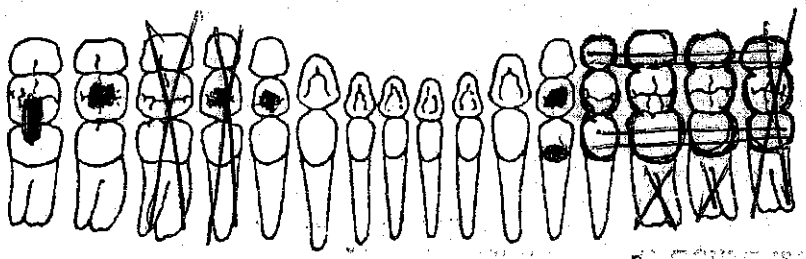
U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

6-3-04

Examination: ☐ Screening ☑ Comprehensive ☐ Periodic



RIGHT 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 LEFT
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17



Occlusion: Class I

Oral Hygiene: Good (Fair) Poor

CPITN: 3 | 2 | 3 / 3 | 2 | 3 — 0 0 0 / 0 0 0

6-3-04 re eval

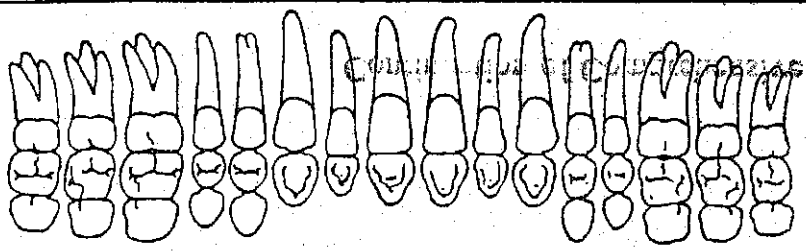
Head & Neck/Soft Tissue: SJWNL

B. lat. clearing

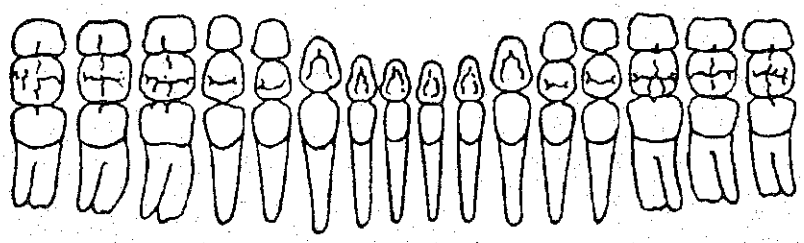
Additional Findings:
- 3 unit bridge 8,9,10
- 4 unit bridge 17-20

D: ___
M: ___
F: ___

Treatment Completed



RIGHT 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 LEFT
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17



Recommended Treatment Plan

☑ Radiographs 6-3-04 gs
VBW 04

☑ Dental Prophylaxis
☑ Oral Hygiene Instruction } 5-21-04 gs

☑ Periodontal Evaluation (9) I II III
6-3-04 gs 0 0 0

☐ Oral Surgical Procedures

☐ Endodontic

☑ Restorative 6-22-04
21-K

☐ Prosthodontic Evaluation

Patient Name: Baker, Darryl Number: 19693039 Sex: (M) F Age: 41
6-30-62

Dentist Signature: W. K. Collins DDS Date: 5-21-04

W. K. Collins, DDS
CDO
FCI McKean

FCI McKean

000150

Federal Bureau of Prisons Clinical Dental Records

Date/Time	#	Diagnosis - Treatment - Remarks
5/21/04 1130hrs		SOA: Routine Care pt P: Comp. HH, soft tissue exam, assessment Pt state No Hx of Dental cleanings. Presents w/ slight > Mod calc + stain. Ultrasonic Q1-4. Selective hand scale, polish, OHI on bridge flossers. 2 pockets 5 mm. NEXT: Comp exam + BWX4 Johnna J Schroll RDH J.J. Schroll, RDH FCI McKean W. K. Collins, DDS CDO FCI McKean
6/03/04 1215hrs		**Continuation of Comprehensive Exam** 1. Charting 3. Oral Cancer Exam 2. Oral Exam 4. Consultation Pt to watch contacts for tx R.F. Greer D.D.S. G.F. Greer D.D.S. W.K. Collins DDS William K. Collins D.D.S.
6-22-04 1130 hrs.		SOA: Rt. canine Px. Med. Hist Rvd NKDA P: Lidocaine 1:100,000 2% ex x1 cl IV resin #21 Px completed R.F. Greer D.D.S. G.F. Greer D.D.S. W.K. Collins William K. Collins, D.D.S. CDO FCI McKean

000151

Language template provided in Spanish ____, or _____

1. Are your currently taking any medication? If so, what? _____	____ YES	✓ NO
2. Are you allergic to or have you had a reaction to any medication or drug? If so, what? _____	____ YES	✓ NO
3. Have you been under the care of a physician during the past two years? If so, why? _____	____ YES	✓ NO
4. Have you been hospitalized in the past two years? If so, why? _____	____ YES	✓ NO
5. Do you have or have you ever had a heart murmur or been treated for a heart condition?	____ YES	✓ NO
6. Have you ever been treated for a tumor, growth, or cancer?	____ YES	✓ NO
7. Have you ever had excessive or prolonged bleeding as a result of a medical condition or medication (ex. Hemophilia or blood thinners)?	____ YES	✓ NO
8. Do you have a latex allergy?	____ YES	✓ NO
9. Do you currently use tobacco products?	____ YES	✓ NO
10. WOMEN ONLY: Are you pregnant?	____ YES	____ NO

Check any of the following that you have had:

____ Congenital heart defects
____ Heart attack or heart problems
____ Stroke
____ Rheumatic fever
____ Mitral Valve Prolapse
____ Anemia (blood problems)
____ Thyroid problems
____ Chronic bronchitis
____ STD (syphilis, gonorrhea, herpes)
____ Angio edema
____ Arthritis
____ Artificial heart valve
____ Hepatitis (☐A ☐B ☐C)
____ Any type of transplant
____ Steroid treatment
____ Sickle Cell Anemia
____ Angina
____ High blood pressure
____ Heart pacemaker
____ Glucose - 6-phosphate dehydrogenase deficiency
____ Epilepsy or seizures
____ Diabetes
____ AIDS or HIV infection
____ Emphysema
____ Tuberculosis (TB)
____ Psychiatric treatment
____ Artificial joint
____ Radiation therapy
____ Asthma

Do you have any disease, condition, or problem not listed? _____

Check any of the following that you have had or applies to you:

____ Sensitive teeth
____ Bleeding gums
____ Food impaction
____ Pain around ear
____ Tooth ache
____ Wear partial dentures
____ Unusual sounds while eating
____ Snoring
____ Blisters on lips or mouth
____ Clenching or grinding
____ Swelling or lumps in mouth/throat
____ Burning tongue
____ Bad breath
____ Decayed teeth
____ Loose teeth
____ Wear dentures

Printed Name: DARRYL BAKER	Signature: Darryl Baker
Reg. No.: #19613-039	Institution: F.C.I. Mckean
Date: 5-21-04	Updated:

(This form may be replicated via WP)

CLINICAL RECORD | DENTAL TREATMENT RECORD (Continuation)

DATE	DIAGNOSIS - TREATMENT - REMARKS	SIGNATURE
05/12/2000 1030hrs	P: A permanent restoration is placed during the routine Care / Maintenance phase, not at sick call. Patient instructed to come back on 12/16/2000 at 0730hrs and a Ketac Silver restoration will be placed in #31.	William Collins DDS W.K. Collins, DDS Chief Dental
03/05/03 0840hrs	S: "My filling came out." (Patient points to #31) (PT#: 0) O: Med Hx Rev'd: NKDA #31, Patient's missing restoration A: #31, missing restoration P: Patient to be scheduled for restorative procedure.	William K. Collins DDS William K. Collins, D.D.S. CDO FCI McKean

(Continued On Reverse Side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade, date; hospital or medical facility)

Baker, Darryl

FCI McKean

REGISTER NO. 17613-039 | WARD NO.

000153

DENTAL TREATMENT RECORD
HRSA-237 (4/95)

EF

DENTAL TREATMENT RECORD (Continuation)

DATE	DIAGNOSIS - TREATMENT - REMARKS	SIGNATURE
04/07/03 0930hrs	P: Patient in 5HU.	William K. Collins, D.D.S. CDO FCI McKean

F.C.I. McKEAN

Bradford, PA 16701

CLINICAL RECORD	DENTAL TREATMENT RECORD (Continuation)	
DATE	DIAGNOSIS—TREATMENT—REMARKS	SIGNATURE
1/4/96 1502	No Anes; #31 (MO) - etch-bond-comp. ("Silux Plus" DY shade); Scheduled for Prophy.	R. CABANAS, D.M.D. CHIEF DENTAL OFFICER
11/16/98 1330	(S) Lost filling (O) #2 c̄ OL filling - L groove missing filling (A) Rev. pulpitis (P) Placed True Vitality.	WS W.G. STERBA DDS
11/17/98 0930	(S) Lost filling (O) #2 c̄ missing OL aspect. Pt states filling was soft!! (A) Rev. Pulpitis (P) TRH.	WS W.G. STERBA DDS
04/28/2000 0920 hrs	S: "I lost a filling out of this tooth"	
	O: Patient points to #02	
	Occlusal restoration partially fractured out	
	Dental caries present	
	A: #02, Fractured restoration 2° chronic	
	caries	over

(Continued On Reverse Side)

DENTAL

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

Baker, Darryl
19613-039
FCI McKean

REGISTER NO.

WARD NO.

DENTAL TREATMENT

HSA-237 (6-74)

000155

SA-237 (6-74)
(reverse)

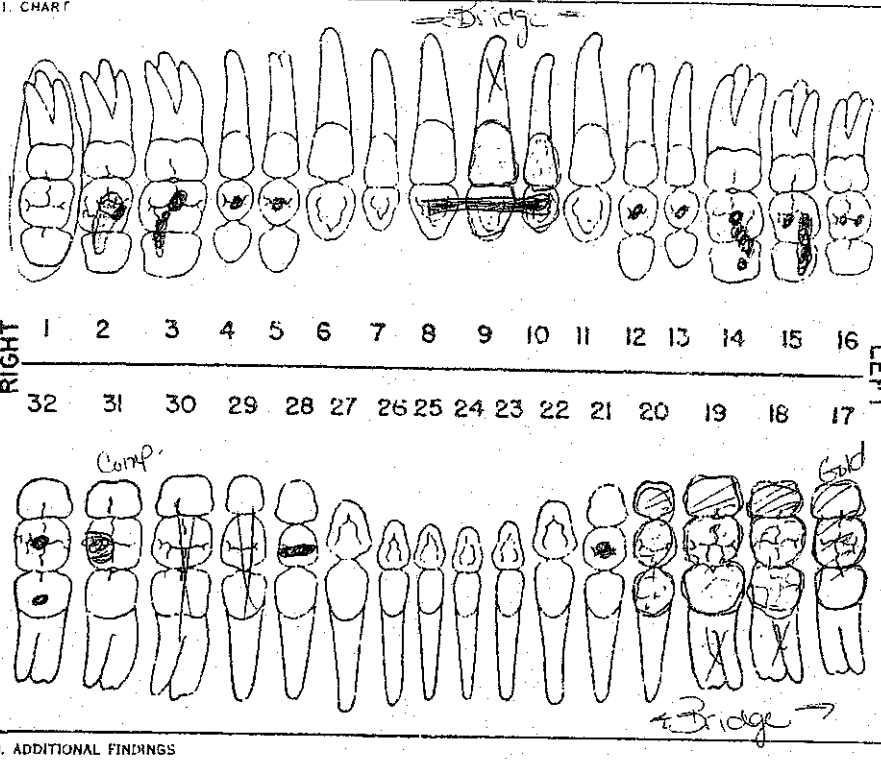
cntd from other side

DENTAL TREATMENT RECORD (Continuation)

DATE	DIAGNOSIS—TREATMENT—REMARKS	SIGNATURE
04/28/2000 0940hrs	P: Lidocaine 2% c 1:100,000 epinephrine x3, caries removal, part of current restoration allowed to remain; Occlusal restoration placed in #02 using Ketac Silver; Occlusal adjustment. Patient instructed to submit a "cop-out" requesting an examination and a prophylaxis.	W.K. Collins, DDS Chief Dental
05/12/2000 1030hrs	S: "My tooth has been hurting me when I chew on it." O: #31, worn down DO resin restoration Med Hx: Reviewed Pan: Root canal therapy has been performed on tooth #31, apices of roots appear WNL DENTAL No percussion Patient may be attempting to abuse sick call. A: No pathology observed other than worn fillings P: Explained to patient that present restoration is satisfactory	W.K. Collins, DDS Chief Dental

CLINICAL RECORD — **DENTAL**

1. CHART



2. ROENTGENOGRAMS
☐ PERIAPICAL ☐ BITE WINGS ☐ OTHER

3. PERIODONTOCLASIA
☐ INCIPIENT ☐ MODERATE ☐ SEVERE
☐ LOCAL ☐ GENERAL

4. CALCULUS
☐ SLIGHT ☐ MODERATE ☐ HEAVY

5. GINGIVAL PATHOLOGY
☐ GINGIVITIS ☐ VINCENT'S INFECTION
☐ STOMATITIS (*Specify*)

6. DENTURE INDICATED (*Include dentures needed after indicated extractions*)
☐ FULL UPPER ☐ FULL LOWER
☐ PARTIAL UPPER ☐ PARTIAL LOWER ☐ REPAIR

7. ABNORMALITIES OF OCCLUSION. ANGLE'S CLASSIFICATION
☐ I ☐ II ☐ III ☐ NORMAL

8. DENTAL CLASSIFICATION

9. TYPE OF EXAMINATION

10. ADDITIONAL FINDINGS

D-C
PL-5
F-F

CHIEF DENTAL OFFICER

11. RECOMMENDATIONS

1) Tx Plan
Prophy Bwcs
2)

12. APPROXIMATE TIME REQUIRED FOR DENTAL TREATMENT

13. DATE: 11/8/95

14. SIGNATURE OF DENTIST: R.A. CABANAS, D.M.D.
R. CABANAS, D.M.D.
CHIEF DENTAL OFFICER

15. GRADE, RATING, OR POSITION

16. TYPE OF BENEFICIARY

17. SEX ☐ M ☐ F

18. RACE

19. AGE

20. SERVICE ☐ INPATIENT ☐ OUTPATIENT ☐ OTHER

PATIENT'S IDENTIFICATION (*For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility*)

Baker, Darryl
19613-039
FCI McKean

22. IDENTIFICATION NO

23. REGISTER NO.

24. WARD NO.

DENTAL

Standard Form 521 (Rev.)
521-108

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975

000157

INFORMATION FOR DENTAL SERVICE *(To be filled in by referring agency)*

26. PRINCIPAL MEDICAL DIAGNOSIS

27. CHECK HERE IF HOSPITALIZED FOR DENTAL TREATMENT ONLY ☐

28. PATIENT REFERRED FOR

29. REMARKS

30. APPROXIMATE PERIOD OF HOSPITALIZATION | 31. DATE | 32. SIGNATURE OF PHYSICIAN

CHIEF DENTAL OFFICER
R. CABANAS, D.M.D.

AUTHORIZATION

33. DENTAL TREATMENT AUTHORIZED

34. DATE | 35. SIGNATURE OF AUTHORIZING DENTIST

36. TREATMENT RECORD

DATE	DIAGNOSIS—TREATMENT—REMARKS	SIGNATURE
CO 11:30 11/8/95	P.O. exam, H Hx Reviewed, Sc, CO & waiting list explained STOWE OHI	R A CABAÑAS/DMD R. CABANAS, D.M.D. CHIEF DENTAL OFFICER
1/29/96/1230	Comprehensive exam – Same charting as 11/8/95 except for Fx of OC composite #2; 2% Lido c 1:0-5 epi x 1.8 cc ("Schein"); #2 (OC) – Varn – AMAL ("Unison"). Needs RPD to maintain existing space #29-30 & to prevent supraeruption of #4. Scheduled for impressions for RPD. (Permanent restoration done on Sick Call today due to low pt load today)	R. CABANAS, D.M.D. CHIEF DENTAL OFFICER R.A. CABAÑAS, DMD R R
5/2/96/0935	Lower alginate impn made. R	R.A. CABAÑAS/DMD
"	Scheduled for Op. #31 (restore MO crack) R	R. CABANAS, D.M.D. CHIEF DENTAL OFFICER
5/6/96/1556	Del RPD. Instructions in use & care given. R	R.A. CABAÑAS/DMD R. CABANAS, D.M.D. CHIEF DENTAL OFFICER

*U.S. Government Printing Office: 1991 — 281-782/40101

F.C.I. McKEAN

Bradford, PA 16701

CLINICAL RECORD	DENTAL TREATMENT RECORD (Continuation)	
DATE	DIAGNOSIS—TREATMENT—REMARKS	SIGNATURE
3/18/96/ 1606	Rescheduled for Up. Not seen today due to unscheduled dept meeting.	R.A CABANAS DMD R. CABANAS, D.M.D. CHIEF DENTAL OFFICER
3/26/96/1555	No show for Call Out 1430, Rec R.A. CABANAS D.M.D.	R. CABANAS, D.M.D. CHIEF DENTAL OFFICER

DENTAL

(Continued On Reverse Side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

Baker, Darryl
19613-039
FCI McKean

REGISTER NO.

WARD NO.

DENTAL TREATMENT RECORD

HSA-237 (6-74)

000159

A-237 (6-74)
(verse)

DENTAL TREATMENT RECORD (Continuation)

DATE	DIAGNOSIS – TREATMENT – REMARKS	SIGNATURE

DENTAL

U.S. Bureau of Prisons
Dental/Medical History Form

1. Are you presently taking any medication? If so, what?_____ Yes (No)

2. Are you allergic to or have you had a reaction to any medication or drug? If so, what?_____ Yes (No)

3. Have you been under the care of a physician during the past two years? If so, why?_____ Yes (No)

4. Have you been hospitalized in the past two years? If so, why?_____ Yes (No)

5. When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you feel very tired? Yes (No)

6. Do your ankles ever swell during the day? Yes (No)

7. Have you ever been treated for a tumor or growth? Yes (No)

8. Have you ever had abnormal bleeding? Yes (No)

9. Have you had any serious difficulty with any previous dental treatment? Yes (No)

Circle any of the following that you have or have had:

Congenital heart defects
Heart attack or heart trouble
Rheumatic Fever
Stroke
Asthma
Anemia(blood problems)
Hepatitis
Thyroid problems
Chronic bronchitis
Venereal disease (syphilis, gonorrhea)
Arthritis
Artificial Heart Valve
Heart murmur
Angina
High blood pressure
Heart pacemaker
Epilepsy or seizures
Diabetes
AIDS or HIV infection
Emphysema
Tuberculosis (TB)
Psychiatric treatment
Artificial Joint Prosthesis

Do you have any disease, condition, or problem not listed? Yes (No)

WOMEN ONLY: Are you pregnant? Yes No

Name Darryl Baker Reg. No. 19613-039

Institution FCI McKean Date 11-8-95

U.S. Bureau of Prisons
Historia Clinica de Odontologia y Medica

1.	¿Que medicinas estra tomando actualmente ? Si es si el nombre_____	SI	NO
2.	¿A que medicinas es usted ALERGICO ? Si es si el nombre_____	SI	NO
3.	¿Tuvo alguna enfermedad durante los ultmos dos anos que requero ver un doctor ? Si es si, por que ?_____	SI	NO
4.	¿Ha estado usted en el Hospital durante los ultimos dos anos ? Si es si, por que ? _____	SI	NO
5.	¿Tiene alguna dificultad para respirar o dolor en el pecho o se siente agotado cuando cuando sube las escaleras ?	SI	NO
6.	¿Se le hinchan los pies ?	SI	NO
7.	¿Tiene cancer ? ¿Desde cuando ?_____	SI	NO
8.	¿Sangra usted con exceso ?	SI	NO
9.	¿Ha tenido problemas con los dientes ?	SI	NO

Que enfermedades o sintomas tiene, que sepa ponga una marka:

Defectos del corazon	Soplo cardiaco
Altaque del corazon	Angina
Fiebre Reumatica	Presion alta
Apoplejia o Derame Cerebral	Marcapasos
Asma o Fatiga	Convulsiones
Anemia (problemas de sangre)	Diabetes
Hepatitis	SIDA o HIV infection
Problemas de tiroides	Enfisema
Bronquitis	Tuberculosis
Enfermedad Venerea (Gonorrea/Sifilis)	Desordenes psiquiatrias
Artritis	Coyunturas artificiales
Valvulas artificiales	

¿Tiene otras enfermedades que no estra en estra lista ? SI NO

Pregunta para las mujeres.
¿Esta usted embarazda o encinta ? SI NO

Nombre_____ Numero_____

Institution_____ Fetcha_____

FEDERAL BUREAU OF PRISONS
DENTAL/MEDICAL HISTORY FORMS

1. Are you presantly taking any medication? Yes (No)
   If so, what?_____

2. Are you allergic to or have you had a reaction to any medication or drugs? If so, what?_____ Yes (No)

3. Have you been under the care of a physician during the past two years? If so, why?_____ Yes (No)

4. Have you been hospitalized in the past two years? Yes (No)
   If so, why?_____

5. When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you feel very tired? Yes (No)

6. Do your ankles ever swell during the day? Yes (No)

7. Have you ever been treated for a tumor or growth? Yes (No)

8. Have you ever had abnormal bleeding? Yes (No)

9. Have you had any serious difficulty with any previous dental treatment? Yes (No)

Circle any of the following that you have or have had:

Congenital heart defects
Heart attack or heart trouble
Rheumatic Fever
Stroke
Asthma
Anemia (blood problems)
Hepatitis
Thyroid problems
Chronic bronchitis
Venereal disease (syphilis, gonorrhea)
Arthritis
Artificial heart valve
Heart murmer
Angina
High blood pressure
Heart pacemaker
Epilepsy or seizures
Diabetes
AIDS or HIV infection
Emphysema
Tuberculosis (TB)
Psychiatric treatment
Artificial prosthesis

Do you have any disease, condition, or problem not listed? Yes (No)

Name Darryl Eaton Reg. No. 19613-039

Institution FDC Milan Date 10-4-95

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U.S. BUREAU OF PRISONS
HISTORIA CLINICA DE CONTOLOGIA y MEDICA

1. Que medicinas estra tomando actualmente? SI ----- NO -----
   Si es si el nombre _____
2. A que medicinas es usted ALERGICO? SI ---- NO -----
   Si es si el nombre _____
3. Tuvo alguna enfermedad duranto los ultmos dos anos que requero ver un doctor? SI ---- NO ----
   Si es si, por que? _____
4. Ha estado usted en el Hospital duranto los ultimos dos anos? Si es si, por quo? SI ---- NO -----
   _____
5. Tiene alguna dificultad para respirar o dolor en el pecho o se siento agotado cuando cuando sube las escaleras? _____ SI ----- NO -----
6. Se le hinchan les pies? _____ SI ----- NO -----
7. Tiene cancer? Desde cuanso? _____ SI ----- NO -----
8. Sangra usted con exceso? _____ SI ----- NO -----
9. Ha tenido problems con los dientes? SI ----- NO -----

Que enfermedades o sintomas tiene, que sepa ponga una marka:

Defectos del corazon	Soplo cardiaco
Altaque del corazon	Angina
Fiebre Reumatica	Presion alta
Apoplejia o Derame Cerebral	Marcapasos
Asma o Fatiga	Convulsiones
Anemia (problems de sangre)	Diabetos
Hepatitis	SIDA o HIV infection
Problemas de tiroides	Enfisoma
Bronquitis	Tuberculosis
Enfermedad Venerea (Gonorrea/Sifilis)	Desordenes psiquiatrias
Artritis	Coyunturas artificiales
Valvulas artificiales	

Tiene otras enfermedades; que no estan en esta lista? SI ----- NO -----

Nombre _____ Numero _____

Institution _____ Fecha _____

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FEDERAL BUREAU OF PRISONS
DENTAL/MEDICAL HISTORY FORMS

1. Are you presantly taking any medication? Yes (No)
   If so, what?_____

2. Are you allergic to or have you had a reaction to any medication or drugs? If so, what?_____ Yes (No)

3. Have you been under the care of a physician during the past two years? If so, why?_____ Yes (No)

4. Have you been hospitalized in the past two years? Yes (No)
   If so, why?_____

5. When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you feel very tired? Yes (No)

6. Do your ankles ever swell during the day? Yes (No)

7. Have you ever been treated for a tumor or growth? Yes (No)

8. Have you ever had abnormal bleeding? Yes (No)

9. Have you had any serious difficulty with any previous dental treatment? Yes (No)

Circle any of the following that you have or have had:

Congenital heart defects	Heart murmer
Heart attack or heart trouble	Angina
Rheumatic Fever	High blood pressure
Stroke	Heart pacemaker
Asthma	Epilepsy or seizures
Anemia (blood problems)	Diabetes
Hepatitis	AIDS or HIV infection
Thyroid problems	Emphysema
Chronic bronchitis	Tuberculosis (TB)
Venereal disease (syphilis, gonorrhea)	Psychiatric treatment
Arthritis	Artificial prosthesis
Artificial heart valve	

Do you have any disease, condition, or problem not listed? Yes No

Name Daryl Baker Reg. No. 19613-039

Institution F.D.C. MILAN Date 6-8-95

000165

U.S. BUREAU OF PRISONS
HISTORIA CLINICA DE CONTOLOGIA y MEDICA

1. Que medicinas estra tomando actualmente? SI ----- NO -----
   Si es si el nombre _____
2. A que medicinas es usted ALERGICO? SI ----- NO -----
   Si es si el nombre _____
3. Tuvo alguna enfermedad duranto los ultmos dos anos que requero ver un doctor? SI ----- NO -----
   Si es si, por que? _____
4. Ha estado usted en el Hospital duranto los ultimos dos anos? Si es si, por quo? SI ----- NO -----
   _____
5. Tiene alguna dificultad para respirar o dolor en el pecho o se siento agotado cuando cuando sube las escaleras? _____ SI ----- NO -----
6. Se le hinchan les pies? _____ SI ----- NO -----
7. Tiene cancer? Desde cuanso? _____ SI ----- NO -----
8. Sangra usted con exceso? _____ SI ----- NO -----
9. Ha tenido problems con los dientes? SI ----- NO -----

Que enfermedades o sintomas tiene, que sepa ponga una marka:

Defectos del corazon	Soplo cardiaco
Altaque del corazon	Angina
Fiebre Reumatica	Presion alta
Apoplejia o Derame Cerebral	Marcapasos
Asma o Fatiga	Convulsiones
Anemia (problems de sangre)	Diabetos
Hepatitis	SIDA o HIV infection
Problemas de tiroides	Enfisoma
Bronquitis	Tuberculosis
Enfermedad Venerea (Gonorrea/Sifilis)	Desordenes psiquiatrias
Artritis	Coyunturas artificiales
Valvulas artificiales	

Tiene otras enfermedades; que no estan en esta lista? SI ----- NO -----

Nombre _____ Numero _____

Institution _____ Fecha _____

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FED ORRECTIONAL INSTITUTIO OSPITAL
FCI MCKEAN, PA

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

O: ALL CONCERNED UNIT: _____ DATE: 8/9/99.
NMATE'S NAME: Baker Darryl DETAIL: _____ REG. NO. 19615-039
For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

IEDICAL CLASSIFICATION STATUS: (Check one and answer questions)

XIDLE: Reason Medical THRU 12 MIDNIGHT 8/10 19 99
) CONVALESCENCE: List any restricted activity for medical reasons. _____
_____ THRU 12 MIDNIGHT _____ 19
) RESTRICTED DUTY: Specify exact restriction and reason. _____
_____ THRU 12 MIDNIGHT _____ 19
) TOTALLY DISABLED:
) FULL DUTY:

Physician or Physician Assistant

DEFINITIONS AND INSTRUCTIONS

LE STATUS - temporary disability not to exceed three days duration including weekends and holidays. Restricted to room except for meals, barbering, religious ser
ll, visits and call outs. No recreation activity.
ONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. Excu
d may not participate in any recreational activities outside the unit.
ESTRICTED DUTY - Restricted from specific activities because of physical or mental handicap. List handicap, work limitation and time period, either specific dat
OTALLY DISABLED - Totally unemployable and unassigned because of mental or physical reasons. Condition generally expected to last indefinitely.
ULL DUTY - No work restrictions because of physical, medical or mental disability.

FEDE[illegible] ORRECTIONAL INSTITUTIC HOSPITAL
FCI MCKEAN, PA

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

TO: ALL CONCERNED UNIT: A A DATE: 2/25/99
INMATE'S NAME: Baker DETAIL: medical REG. NO. 19613-039
For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

MEDICAL CLASSIFICATION STATUS: (Check one and answer questions)

( ) IDLE: Reason Medical THRU 12 MIDNIGHT 2/26 19 99
( ) CONVALESCENCE: List any restricted activity for medical reasons. _____
_____ THRU 12 MIDNIGHT _____ 19 ____
( ) RESTRICTED DUTY: Specify exact restriction and reason. _____
_____ THRU 12 MIDNIGHT _____ 19 ____
( ) TOTALLY DISABLED:
( ) FULL DUTY:

Physician or Physician Assistant

DEFINITIONS AND INSTRUCTIONS

000167

IDLE STATUS - temporary disability not to exceed three days duration including weekends and holidays. Restricted to room except for meals, barbering, religious services, sick call, visits and call outs. No recreation activity.
CONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. Excused from work and may not participate in any recreational activities outside the unit.
RESTRICTED DUTY - Restricted from specific activities because of physical or mental handicap. List handicap, work limitation and time period, either specific date or indefiite.
TOTALLY DISABLED - Totally unemployable and unassigned because of mental or physical reasons. Condition generally expected to last indefinitely.
FULL DUTY - No work restrictions because of physical, medical or mental disability.

FEDERAL (RRECTIONAL INSTITUTION OSPITAL
FCI MCKEAN, PA

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

TO: ALL CONCERNED Baker, D UNIT: 1A DATE: 5/15/98
INMATE'S NAME: _____ DETAIL: Cnv, cop REG. NO. 19613-039

For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

MEDICAL CLASSIFICATION STATUS: (Check one and answer questions)

(X) IDLE: Reason _____ THRU 12 MIDNIGHT 5/17 19 98
( ) CONVALESCENCE: List any restricted activity for medical reasons. _____ THRU 12 MIDNIGHT _____ 19 ___
( ) RESTRICTED DUTY: Specify exact restriction and reason. _____ THRU 12 MIDNIGHT _____ 19 ___
( ) TOTALLY DISABLED:
( ) FULL DUTY:

Rest
No Sports/Rec x 1wk

T. Montgomery, MLP
Physician or Physician Assistant

DEFINITIONS AND INSTRUCTIONS

IDLE STATUS - temporary disability not to exceed three days duration including weekends and holidays. Restricted to room except for meals, barbering, religious services, sick call, visits and call outs. No recreation activity.
CONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. Excused from work and may not participate in any recreational activities outside the unit.
RESTRICTED DUTY - Restricted from specific activities because of physical or mental handicap. List handicap, work limitation and time period, either specific date or indefiite.
TOTALLY DISABLED - Totally unemployable and unassigned because of mental or physical reasons. Condition generally expected to last indefinitely.
FULL DUTY - No work restrictions because of physical, medical or mental disability.

/

FEDERAL \ RRECTIONAL INSTITUTION OSPITAL
FCI MCKEAN, PA

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

O: ALL CONCERNED UNIT: _____ DATE: 1/23/98
NMATE'S NAME: Baker, Darryl DETAIL: _____ REG. NO. 19613-039

For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

MEDICAL CLASSIFICATION STATUS: (Check one and answer questions)

(IDLE: Reason _____ THRU 12 MIDNIGHT 1/24 19 98
) CONVALESCENCE: List any restricted activity for medical reasons. _____ THRU 12 MIDNIGHT _____ 19 ___
) RESTRICTED DUTY: Specify exact restriction and reason. _____ THRU 12 MIDNIGHT _____ 19 ___
) TOTALLY DISABLED:
) FULL DUTY:

Physician or Physician Assistant

000168

DEFINITIONS AND INSTRUCTIONS

DLE STATUS - temporary disability not to exceed three days duration including weekends and holidays. Restricted to room except for meals, barbering, religious services, sick all, visits and call outs. No recreation activity.
ONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. Excused from work nd may not participate in any recreational activities outside the unit.
ESTRICTED DUTY - Restricted from specific activities because of physical or mental handicap. List handicap, work limitation and time period, either specific date or indefiite.

FEDERAL CORRECTIONAL INSTITUTION HOSPITAL
FCI MCKEAN, PA

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

TO: ALL CONCERNED UNIT: _____ DATE: 11/25/97,
INMATE'S NAME: Baker Darryl DETAIL: _____ REG. NO. 19613-039

For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

MEDICAL CLASSIFICATION STATUS: (Check one and answer questions)

(X) IDLE: Reason Medical THRU 12 MIDNIGHT 11/25 1997
( ) CONVALESCENCE: List any restricted activity for medical reasons. _____ THRU 12 MIDNIGHT _____ 19___
( ) RESTRICTED DUTY: Specify exact restriction and reason. _____ THRU 12 MIDNIGHT _____ 19___
( ) TOTALLY DISABLED:
( ) FULL DUTY:

[signature] M.D.
Physidian or Physician Assistant

DEFINITIONS AND INSTRUCTIONS

IDLE STATUS - temporary disability not to exceed three days duration including weekends and holidays. Restricted to room except for meals, barbering, religious services, sick call, visits and call outs. No recreation activity.
CONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. Excused from work and may not participate in any recreational activities outside the unit.
RESTRICTED DUTY - Restricted from specific activities because of physical or mental handicap. List handicap, work limitation and time period, either specific date or indefiite.
TOTALLY DISABLED - Totally unemployable and unassigned because of mental or physical reasons. Condition generally expected to last indefinitely.
FULL DUTY - No work restrictions because of physical, medical or mental disability.

FEDERAL CORRECTIONAL INSTITUTION HOSPITAL
FCI MCKEAN, PA

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

TO: ALL CONCERNED UNIT: 1A DATE: 12-30-96
INMATE'S NAME: Baker, Darryl DETAIL: CMS REG. NO. 19613-039

For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

MEDICAL CLASSIFICATION STATUS: (Check one and answer questions)

(X) IDLE: Reason Muscle Sprain THRU 12 MIDNIGHT 12-31, 1996
( ) CONVALESCENCE: List any restricted activity for medical reasons. _____ THRU 12 MIDNIGHT _____ 19___
( ) RESTRICTED DUTY: Specify exact restriction and reason. _____ THRU 12 MIDNIGHT _____ 19___
( ) TOTALLY DISABLED:
( ) FULL DUTY:

SHARONE A. WALTER PHYSICIAN ASSISTANT
S. Walter P.A.
Physician or Physician Assistant

DEFINITIONS AND INSTRUCTIONS

000169

IDLE STATUS - temporary disability not to exceed three days duration including weekends and holidays. Restricted to room except for meals, barbering, religious services, sick call, visits and call outs. No recreation activity.
CONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. Excused from work and may not participate in any recreational activities outside the unit.
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FEDERAL CORRECTIONAL INSTITUTION HOSPITAL
FCI MCKEAN, PA

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

TO: ALL CONCERNED UNIT: 1A DATE: 12-26-96
INMATE'S NAME: Baker, Darryl DETAIL: CMS REG. NO. 19613-039

For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

MEDICAL CLASSIFICATION STATUS: (Check one and answer questions)

(X) IDLE: Reason Muscle Sprain THRU 12 MIDNIGHT 12-27 19 96
( ) CONVALESCENCE: List any restricted activity for medical reasons. _____ THRU 12 MIDNIGHT _____ 19 ___
( ) RESTRICTED DUTY: Specify exact restriction and reason. _____ THRU 12 MIDNIGHT _____ 19 ___
( ) TOTALLY DISABLED:
( ) FULL DUTY:

S. Walter P.A.
SHARONE A. WALTER PHYSICIAN ASSISTANT
Physician or Physician Assistant

DEFINITIONS AND INSTRUCTIONS

IDLE STATUS - temporary disability not to exceed three days duration including weekends and holidays. Restricted to room except for meals, barbering, religious services, sick call, visits and call outs. No recreation activity.
CONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. Excused from work and may not participate in any recreational activities outside the unit.
RESTRICTED DUTY - Restricted from specific activities because of physical or mental handicap. List handicap, work limitation and time period, either specific date or indefiite.
TOTALLY DISABLED - Totally unemployable and unassigned because of mental or physical reasons. Condition generally expected to last indefinitely.
FULL DUTY - No work restrictions because of physical, medical or mental disability.

FEDERAL CORRECTIONAL INSTITUTION HOSPITAL
FCI MCKEAN, PA

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

TO: ALL CONCERNED UNIT: 1A DATE: 5/21/96
INMATE'S NAME: Baker, Darryl DETAIL: Clinic REG. NO. _____

For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

MEDICAL CLASSIFICATION STATUS: (Check one and answer questions) 19613-039

( ) IDLE: Reason _____ THRU 12 MIDNIGHT 5/21 19 96
( ) CONVALESCENCE: List any restricted activity for medical reasons. _____ THRU 12 MIDNIGHT _____ 19 ___
( ) RESTRICTED DUTY: Specify exact restriction and reason. _____ THRU 12 MIDNIGHT _____ 19 ___
( ) TOTALLY DISABLED:
( ) FULL DUTY:

OWEN CONNELLY, FMG, PA
OWEN CONNELLY, FMG
Physician or Physician Assistant

DEFINITIONS AND INSTRUCTIONS

000170

IDLE STATUS - temporary disability not to exceed three days duration including weekends and holidays. Restricted to room except for meals, barbering, religious services, sick call, visits and call outs. No recreation activity.
CONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. Excused from work and may not participate in any recreational activities outside the unit.
RESTRICTED DUTY - Restricted from specific activities because of physical or mental handicap. List handicap, work limitation and time period, either specific date or indefiite.
TOTALLY DISABLED - Totally unemployable and unassigned because of mental or physical reasons. Condition generally expected to last indefinitely.
FULL DUTY - No work restrictions because of physical, medical or mental disability.

FEDERAL CORRECTIONAL INSTITUTION HOSPITAL
FCI MCKEAN, PA

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

TO: ALL CONCERNED UNIT: 1A DATE: 5-13-96
INMATE'S NAME: BARKER DARRYL DETAIL: UNICOR REG. NO. 19613-039

For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

MEDICAL CLASSIFICATION STATUS: (Check one and answer questions)

( ) IDLE: Reason _____ THRU 12 MIDNIGHT 5-14 1996
( ) CONVALESCENCE: List any restricted activity for medical reasons. _____
_____ THRU 12 MIDNIGHT _____ 19___
( ) RESTRICTED DUTY: Specify exact restriction and reason. _____
_____ THRU 12 MIDNIGHT _____ 19___
( ) TOTALLY DISABLED:
( ) FULL DUTY: Strict rest except for meals
Catheter Restriction x 2 weeks

A F GUNTHER M D
Physician or Physician Assistant

DEFINITIONS AND INSTRUCTIONS

IDLE STATUS - temporary disability not to exceed three days duration including weekends and holidays. Restricted to room except for meals, barbering, religious services, sick call, visits and call outs. No recreation activity.
CONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. Excused from work and may not participate in any recreational activities outside the unit.
RESTRICTED DUTY - Restricted from specific activities because of physical or mental handicap. List handicap, work limitation and time period, either specific date or indefiite.
TOTALLY DISABLED - Totally unemployable and unassigned because of mental or physical reasons. Condition generally expected to last indefinitely.
FULL DUTY - No work restrictions because of physical, medical or mental disability.

FEDERAL CORRECTIONAL INSTITUTION HOSPITAL
FCI MCKEAN, PA

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

TO: ALL CONCERNED Barker Darryl UNIT: 1A DATE: 1/30/96
INMATE'S NAME: _____ DETAIL: Welding Shop REG. NO. 19613-039

For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

MEDICAL CLASSIFICATION STATUS: (Check one and answer questions)

( ) IDLE: Reason _____ THRU 12 MIDNIGHT 1/30 1996
( ) CONVALESCENCE: List any restricted activity for medical reasons. _____
_____ THRU 12 MIDNIGHT _____ 19___
( ) RESTRICTED DUTY: Specify exact restriction and reason. _____
_____ THRU 12 MIDNIGHT _____ 19___
( ) TOTALLY DISABLED:
( ) FULL DUTY: No Gym / exercise 2 weeks

J GOMEZ, FMG, PA
Physician or Physician Assistant

000171

DEFINITIONS AND INSTRUCTIONS

IDLE STATUS - temporary disability not to exceed three days duration including weekends and holidays. Restricted to room except for meals, barbering, religious services, sick call, visits and call outs. No recreation activity.
CONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. Excused from work and may not participate in any recreational activities outside the unit.
RESTRICTED DUTY - Restricted from specific activities because of physical or mental handicap. List handicap, work limitation and time period, either specific date or indefiite.
TOTALLY DISABLED - Totally unemployable and unassigned because of mental or physical reasons. Condition generally expected to last indefinitely.

FEDERAL CORRECTIONAL INSTITUTION HOSPITAL
FCI MCKEAN, PA

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

TO: ALL CONCERNED Baker, Darryl UNIT: 1A DATE: 11/20/95
INMATE'S NAME: DETAIL: CMS REG. NO. 19613-039

For Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

MEDICAL CLASSIFICATION STATUS: (Check one and answer questions)

( ) IDLE: Reason _____ THRU 12 MIDNIGHT 11/24 1995
(X) CONVALESCENCE: List any restricted activity for medical reasons. _____
_____ THRU 12 MIDNIGHT _____ 19___
( ) RESTRICTED DUTY: Specify exact restriction and reason. _____
_____ THRU 12 MIDNIGHT _____ 19___
( ) TOTALLY DISABLED:
( ) FULL DUTY:

O. CONNELLY, FMG, PA
Physician or Physician Assistant

DEFINITIONS AND INSTRUCTIONS

IDLE STATUS - temporary disability not to exceed three days duration including weekends and holidays. Restricted to room except for meals, barbering, religious services, sick call, visits and call outs. No recreation activity.
CONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. Excused from work and may not participate in any recreational activities outside the unit.
RESTRICTED DUTY - Restricted from specific activities because of physical or mental handicap. List handicap, work limitation and time period, either specific date or indefiite.
TOTALLY DISABLED - Totally unemployable and unassigned because of mental or physical reasons. Condition generally expected to last indefinitely.
FULL DUTY - No work restrictions because of physical, medical or mental disability.

FEDERAL CORRECTIONAL INSTITUTION HOSPITAL
FCI MCKEAN, PA

IDLE, CONVALESCENT AND CHANGE IN WORK CLASSIFICATION STATUS

): ALL CONCERNED Baker, Darryl UNIT: 1A DATE: 11/20/95
MATE'S NAME: DETAIL: CMS REG. NO. 19613039

'or Medical purposes, the inmate named above has been authorized the work and/or activity status listed below the reason(s) and the time shown.

EDICAL CLASSIFICATION STATUS: (Check one and answer questions)

) IDLE: Reason _____ THRU 12 MIDNIGHT 11/20 1995
) CONVALESCENCE: List any restricted activity for medical reasons. _____
_____ THRU 12 MIDNIGHT _____ 19___
) RESTRICTED DUTY: Specify exact restriction and reason. _____
_____ THRU 12 MIDNIGHT _____ 19___
) TOTALLY DISABLED:
) FULL DUTY:

No sport, no weight lifting at gym
X 2 meals

GOMEZ, FMG, PA
Physician or Physician Assistant
GOMEZ, FMG

DEFINITIONS AND INSTRUCTIONS

LE STATUS - temporary disability not to exceed three days duration including weekends and holidays. Restricted to room except for meals, barbering, religious services, sick ll, visits and call outs. No recreation activity.
ONVALESCENT STATUS - Recovery period for operation, injury, or serious illness. Not less than four days and not to exceed thirty days, subject to renewal. Excused from work ... participate in any recreational activities outside the unit.
... limitation and time period, either specific date or indefiite.

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U.S. DEPARTMENT OF JUSTICE
Federal Bureau of Prisons

INMATE INJURY ASSESSMENT AND FOLLOWUP
(Medical)

1. Institution	2. Name of Injured	3. Register Number
Elk	Baker, Darryl	19613-039
4. Injured's Duty Assignment	**5. Housing Assignment**	**6. Date and Time of Injury**
SHU	SHU 130	8/11/05 ≅ 1230pm
7. Where Did Injury Happen (*Be specific as to location*)	***Work Related?*** ☐ Yes ☒ No	**8. Date and Time Reported for Treatment**
FSC Visity Room		8/12/05 1730pm

9. Subjective: (*Injured's Statement as to How Injury Occurred*)(*Symptoms as Reported by Patient*)

"The restraints were excessively tight and my wrists hurt." "It hurt my ankles too."

unable to sign
Signature of Patient

10. Objective: (*Observations or Findings from Examination*)

X-Rays Taken _____ *Not Indicated* _____
X-Ray Results

C/o soreness on b/lat wrists ø swelling, ø redness, full ROM of wrists d/stal circulation intact ø visible or palpable abnormalities. C/o b/lat ankle pain, ø swelly, ø redness, full ROM of ankles ø visible abnormality noted.

11. Assessment: (*Analysis of Facts Based on Subjective and Objective Data*)

A/t in health mt

12. Plan: (*Diagnostic Procedures with Results, Treatment and Recommended Follow-up*)

Pt Ed tylenol or motrin PRN for Pain flu ☐ SHU

PA/sick call for further CDs

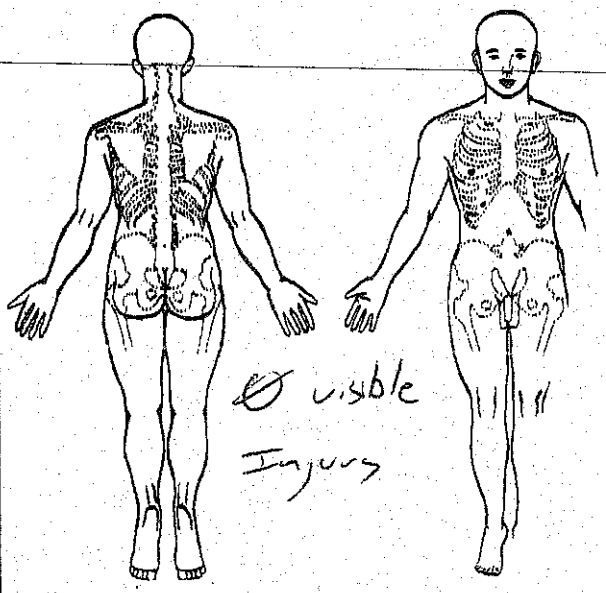
13. This Injury Required:

- ☐ a. No Medical Attention
- ☐ b. Minor First Aid
- ☐ c. Hospitalization
- ☒ d. Other (*explain*) Exam

MICHELE J. KELLER, D.O.
CLINICAL DIRECTOR

- ☐ e. Medically Unassigned
- ☐ f. Civilian First Aid Only
- ☐ g. Civilian Referred to Community Physician

C McConnell RN
Signature of Physician or Physician Assistant



000173

Self Carboned Form – If ballpoint pen is used, **PRESS HARD**

Original – Medical File
Canary – Safety
[illegible] – Supervisor (Work related only)

U.S. DEPARTMENT OF JUSTICE
Federal Bureau of Prisons

INMATE INJURY ASSESSMENT AND FOLLOWUP
(Medical)

1. Institution	2. Name of Injured	3. Register Number
FCI McKean	BAKER, DARRYL	19613-039
4. Injured's Duty Assignment	**5. Housing Assignment**	**6. Date and Time of Injury**
Unicor	AA	2/27/04 2000hr
7. Where Did Injury Happen *(Be specific as to location)*	*Work Related?* ☐ Yes ☒ No	**8. Date and Time Reported for Treatment**
Housing AA Cell #129		2/29/04 0950hr

9. Subjective: *(Injured's Statement as to How Injury Occurred)(Symptoms as Reported by Patient)*

(1.) 41 y/o AA ♂ c/o LT. Face & Eye Pain 2° assaulted by 2-Im's c̄ ∅ LOC, Also c/o (2.) Minor Pain Swelling & Abrasions of Rt Chest & Back, RUE, B/L HANDS.
(3.) Reports Episodic Epistaxis - 1st 24hrs s/p
(4.) c/o Resolving (↓) Parasthesia Lt Face & Maxilla Dentition
DENIES: DIZZY - HA - VISION LOSS - LOC -

Darryl Baker
Signature of Patient

10. Objective: *(Observations or Findings from Examination)* — *X-Rays Taken* ____ *Not Indicated* ✓

X-Ray Results

CAOx3, Mod distress, ambulatory, Flat affect
HEAD ⇒ NC/AT; EARS → ∅ Bld, TM's INTACT c̄ ∅ Fld./Bld.; FACE ⇒ LT. mild Tender c̄ Ecchymosis & Swelling ∅ step-off/Deformity; skin intact c̄ ⊕ periorbital ecchymosis/Edema ⊕ Tender, ∅ step-off; NOSE → neutral NT Pyramid & Tip c̄ mild ecchymosis Lt Lateral Nose ⇒ ⊕ DNS-RT, BILAT. MUCOSAL Edema LT>RT c̄ Dried & Fresh Bld. Left ∅ Visible Rupture; Chest/Back + UE's (See DIAGRAM); NEURO → CN's II-XII Intact; PERRLA; LT. Conjunctivitis, EOMI

11. Assessment: *(Analysis of Facts Based on Subjective and Objective Data)* (7.) Epistaxis ∅ Fx.

(1.) Periorbital Soft Tissue Trauma Ecchymosis/Edema ∅ Fx
(2.) LT. MAXILLA/ZYGOMA CONTUSION ∅ Fx (4, 5.) Contusions, Sprain
(3.) CONTUSION ⊕ ABRASION (Superficial) ⊕ Superficial abrasions
& (6.)

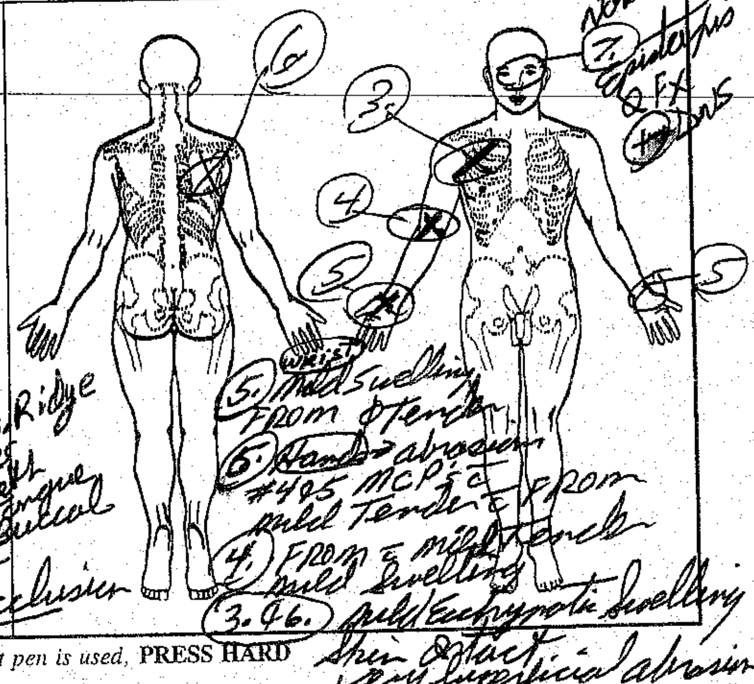
12. Plan: *(Diagnostic Procedures with Results, Treatment and Recommended Follow-up)* (7) Epistaxis Prophylaxis Instructions.

(1.) Epinephrine 1:1000 3cc Topical LT. NOSE x 1
(2.) Snellen Eye Exam Acuity @ 20/25 Bilat
(3.) Educate Counsel re. Trauma c̄ RTC-PRN
(4.) Understands

13. This Injury Required:

☐ a. No Medical Attention
☒ b. Minor First Aid
☐ c. Hospitalization
☐ d. Other *(explain)*

☐ e. Medically Unassigned
☐ f. Civilian First Aid Only
☐ g. Civilian Referred to Community Physician



Signature of Physician or Physician Assistant
Robert E. Piotrowski, PA-C
FCI McKean

Self Carboned Form – If ballpoint pen is used, PRESS HARD

Original – Medical File
Canary – Safety
Pink – Work Supervisor *(Work related only)*

Reviewed by D. Olson, MD

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